RUNNING HEAD: EPIDEICTIC RHETORIC SIZED TO FIT

Epideictic rhetoric sized to fit: the White Coat ceremony

Abstract

In 1993, Columbia University staged a ceremony to welcome its incoming class of medical students. Twelve years later, ninety percent of medical schools in the United States host an annual White Coat ceremony, in which they cloak their new medical students in short white coats and invite a distinguished physician to speak to them about the responsibilities of pursuing a profession in medicine. The explosive growth in this new ceremony comes at a time when medical educators are caught between malaise and despair on the subject of how ethics ought to be taught. Some have attempted to synthesize the kernel of medical ethics using Aristotle's concept of *phronesis,* or practical wisdom. A reading of White Coat speeches in the past five years confirms that major themes in the speakers' texts encourage medical students to concentrate on subordinating science to experience, subordinating proper medical procedure to a patient's needs and wishes, and always putting the relationship with the patient first.

We are not present at the birth of the White Coat Ceremony, but we are present at the end of its childhood; the teenage years loom ahead. Begun in 1993 at Columbia University, the event caught the imagination of medical school deans from coast to coast, with a little encouragement from the Robert Wood Johnson and Arnold P. Gold Foundations, and now each year "takes place at more than 90% of schools of medicine and osteopathy in the United States, as well as at all four medical schools in Israel" (Arnold P.Gold Foundation, n.d., ¶ 2). Students gather, often accompanied by their parents, to don a short white coat whose length differentiates them from fully qualified doctors, to (at some schools) recite an oath promising allegiance to the medical field's core values, and, judging from the dozens of medical school student organization web pages, to pose for countless pictures, both individually and in groups.

And, finally, to hear a speaker. From the beginning, the White Coat Address has been a recommended element of the ceremony. A doctor, usually a faculty member, says a few words appropriate to the occasion, welcoming students to the starting gate of their medical education. It is customary to tell several war stories, to speak lovingly of William Osler, to quote approvingly several of his more lip-smacking epigrams about a doctor's dedication to humanity. Physicians, often only weeks away from retirement, blend soaring promises of excitement, joy, fulfillment and inner peace with warnings that a doctor's career is stressful, painful, and full of unpredictable twists. And then students are dismissed to begin their studies.

The concept has attracted detractors. Veatch (2002) argues that students cannot place any of the message into context because they have virtually no knowledge or experience of any matter the speakers discuss. He warns that the appearance of consensus created by the students' recitation of the oath is a dangerous illusion, and asks, "Is it good for physicians to abandon the religious, cultural, ethnic, and national identities that they bring with them on their first day of medical school and replace them with a new identity bonded to a new group who share none of

those rich identities but replace them with a new professional-priestly bond?" (p. 7) Wear (1998) cautions that the ceremony "…may actually promote unselfconsciousness rather than remind physicians to show compassion and humility. Doctors may *become* the coat, sometimes keenly aware of and sometimes unconscious of the way persons respond to them – with deference, respect, shyness, self-consciousness, or even silence" (p. 736). One graduate of Harvard Medical School, in her memoir of the experience, punctures the Gold Foundation's hopeful description of the ceremony as "a hands-on experience that underscores the bonding process" (¶ 3), calling it "anything but ceremonious." At her White Coat Ceremony,

> I stood near the end of a long, disorganized line in the Holmes Society office, waiting to receive my coat. By the time I reached the front, all the small coats had been given out, and I received one several sizes too large. "You can trade with someone," the administrative assistant said. A day later, wearing our coats still creased from the packaging, we attended our first patient clinic as formal members of the medical world. (Rothman, 1999, p. 2)

Although many students comment favorably on the event (Gillon, 2000; Wang 1996), a theme running through their own accounts of the experience is a powerful ambivalence toward their abrupt role change. One student explains, "I struggled with being identified as a medical student and was quick to point out that I wasn't a doctor yet," and complains that the ceremony "seemed precocious to me – surely a measly second-year didn't deserve to be strutting around hospital corridors in a white coat (even if it was a short one)" (Ashgar, 2004, p. 27). A sociologist interviewing medical students reports that they only grudgingly accepted "the importance of the props to successful accomplishment of their role play – even as it enhanced the feeling of artifice: 'During third year when we got to put the little white coat on and carry some instruments around the hospital, have a name tag . . . it definitely felt like role-playing'" (Beagan,

2001, p. 283). Rothman describes a practical round in which a patient submitted to an invasive prostate exam, which was repeated three times so each student could have a go. She reports her own discomfort at witnessing the encounter, her mother's incredulity when told of it over the phone: "The patient actually *allowed* that?" (p. 1), and concludes, "The only way to explain the patient's willingness was Roy's white coat" (p. 1). She also reports that in the school's annual talent show, students sang and danced to Madonna's song, *Vogue:*

> Wear the coat
>
> Let patients think you're a doctor [think you're a doctor]
>
> Hey hey hey
>
> Put on, coat
>
> Never let on that you don't know
>
> You know you can do it. (p. 86)

While Rothman confesses that her newfound identity "was not an affiliation I was ready to claim as a first-year medical student" (p. 2), and complains that "I felt as if I wore the scarlet letter, but no one knew what it stood for" (p. 3), her ultimate response is not negative, but rather ambitious: "While I fully appreciate the opportunity afforded me by these patients to learn how to interview and perform simple procedures, I looked forward to a time when I would be able to offer my students more concrete skills. I looked forward to growing into my white coat" (p. 4).

It is not surprising that the ceremony and address apparently work only incomplete magic. Doctors, by temperament and heritage, tend to be a far from ideal audience for epideictic messages. Freidson (1972) describes fully acculturated doctors as impatient with overarching principles, attracted to the concrete and practical: "The request is, 'Doctor, do something,' not, 'Doctor, tell me if this is true or not'" (p. 22). Siraisi (2004) reports that speakers addressing the incoming class of a sixteenth century medical school had to tread a very narrow path; if they

erred toward the technical, they might "be interrupted by whistles and catcalls," while a speaker who spoke instead in fashionable flowery language suited to the special occasion orations of the period "might expect a glaze of tedium to come over his audience" (p. 201). What, then, explains the ceremony's explosive popularity, moving from one celebration twelve years ago to near uniform adoption across the United States?

Doctors with scalpels and prescription pads are in a position to wreak terrible suffering on innocent patients if they drift from intent focus on giving each patient their attention, diligence, and very best decisions, and whenever that focus crumbles, the headlines fill with gruesome reports of scandal, followed immediately by calls for more medical school coursework in ethics. That response, unfortunately, may be more cosmetic or cathartic than effective. Hafferty and Franks (1994) deride medical ethics classes as medicine's "'magic bullet'," listing as among the issues that have prompted calls for more rigorous ethics training, "the breakdown of the physician-patient relationship … medicine's loss of advocacy, the emergence of the patient-as-consumer, and the moral complexities of technological medicine" (p. 861). Apker and Eggly explain that the humanizing exercises in ethics classes are offset and erased by the structure of the core science curriculum, lamenting that "The identity of doctor as an objective, emotionally distant, scientific authority is thus strengthened and perpetuated even as medical schools and residency programs require instruction in the social and psychological aspects of illness and training in 'people skills' such as friendliness, sensitivity, and empathy" (2004, p. 426). Bloom (1989) makes the case in even stronger terms, insisting that all efforts to launch innovative medical school curricula that can promise more humane physicians are nothing more than window dressing for medical faculties whose top priority is the chase for grant dollars and publication lists. Eckenfels concludes:

> There is an incredible irony in all of this – an awareness that something fundamental is missing in the way future physicians are trained and yet an inability to do anything substantive to institute real change. It is as if the profession is incapacitated when it comes to taking action. There seems to be a desire for an atavistic revival of core values, but there is also a fear that any serious changes in the system would result in the breakdown of norms, disintegration of structure, and, most importantly, loss of control. (2001, p. 716)

The White Coat ceremony's thirteen years of explosive growth, then, may be a frustrated response to institutional pressure for medical schools to produce doctors who won't make terrible, headline-grabbing mistakes, combined with the increasingly evident impotence of traditional ethics training. Many medical educators have accepted, publicly, as one White Coat speaker confessed, "Teaching benevolence and nonmalfeasance to physicians may not be accomplishable. As a residency director colleague of mine likes to say, 'I can't teach them what their mothers couldn't'" (Falk, 2003, p. 154), and have joined Suchman et al. in declaring that

> … we do not believe that standardized prescriptive interventions, measurements, and benchmarking will work. Instead, we have adopted the nonlinear perspective of 'making ripples in a pond,' envisioning our work as introducing constructive disturbances in existing patterns of interaction that other people might then adopt, modify, and propagate (2004, p. 501).

In desperation, they have turned to Aristotle. Resuscitating a concept from the *Nicomachean Ethics,* many bioethicists and medical educators have declared that the properly trained physician must be, or become, a *phronimos,* and must work out the proper practice of medicine not as a set of principles, but as excellence in particular decisionmaking adapted wholly to the details of each situation: *phronesis.* Aristotle defined *phronesis,* or practical reason, as "…

a true and reasoned state of capacity to act with regard to the things that are good or bad for man. For while making has an end other than itself, action cannot; for good action itself is its end" (VI.5, ¶ 1). It "must also recognize the particulars; for it is practical, and practice is concerned with particulars" (VI.7, ¶ 5). Physicians attempting to appropriate the term have compared it to the ability to drive an automobile, which cannot be learned to competence simply from studying a book, but must be acquired through practice (Dowie, 2000), and the difference between mechanical performance of a musical piece and the virtuosity to make the piece come alive through expressive interpretation (Dowie, 2000; Tyreman, 2000). Davis pegs the concept to being *patient-centered* in the practice of medicine, arguing that "*phronesis* presents a paradigm of the rationality of the physician's effort to resolve the epistemological and ontological problem inherent in every clinical encounter, the problem of how to apply general, abstract knowledge to the needs of this individual patient" (1997, pp. 173-174).

Acceptance of ambiguity is a closely allied element. Aristotle explains that *phronesis* involves wisdom regarding matters that *could be otherwise:* "Now if what is healthy or good is different for men and for fishes, but what is white or straight is always the same, any one would say that what is wise is the same but what is practically wise is different" (VI.7, ¶ 3) Freidson, explaining the uncomfortable fit between science and medicine, identifies the variability in what health can mean for each individual: "…the mere fact of individual variability poses a constant problem for assessment that emphasizes the necessity for personal firsthand examination of every individual case and the difficulty of disposition on some formal, abstract scientific basis" (1972, p. 164). This disconnect, according to Kirk-Smith and Stretch (2003), is the point of strain between medical practice and science, the sore spot that entices doctors to throw themselves excessively into scientizing a patient's messages, trying to discipline symptoms into a recognizable disease. Abizadeh draws an analogy between audience analysis, apprehension of

"the constitution, customs, ethos, and pathê of his audience" and *phronesis'* focus upon the "the morally salient particular features of the circumstance at hand" (2002, pp. 283-284). For the same reason that speakers who try to fit audiences into a canned, unadapted text squander much of their potential, the *phronetic* perspective drives doctors to truly *see* patients, and apply medicine only as a set of first clues, a jumping off point for investigating the patient and understanding in an unrepeatable way what separates her or him from health and what points map the journey back. Lyne indicates that advances in medical technology have rendered even the patient's constitution unsettled, leaving physicians with less of a firm grounding to begin decisionmaking than in Aristotle's day: "The very nature of personal agency has been complicated by the discourse of genetic codes and biological traits— a discourse that both textualizes the body and medicalizes personality. In this environment, the art of practical reason becomes even more important" (2001, p. 13).

Thomas Farrell's account of *phronesis,* in his book-length treatment of rhetorical culture, deepens this application of Aristotle's taxonomy of wisdoms. Asserting that "the individual agent would be unable to cultivate qualities of phronēsis if left entirely to his or her own solitary devices," Farrell draws attention back to Aristotle's insistence on the *deliberative* element of practical wisdom: not only is it oriented to immediate action, but it emerges from an interchange of arguments between interested parties. A doctor who begins by approaching each patient as an *individual*, rather than an assemblage of charts, processes and interdependent systems catalogued in medical textbooks, and who continues by *interacting* meaningfully and attentively with the individual, is better prepared to understand that "The potential harms in these conflicts are not solved by yes-no bytes in a computer program. They present degrees of potential harm in human beings to whom we are attached, and not objects sandwiched against each other" (Pellegrino &

Thomasma, 1993, p. 89). This is the natural offset to the medical school's traditional core curriculum, which drives a wedge between physicians and patients:

> Their ability to talk to people becomes corrupted by the educational process. They learn the language of medicine but they give up some of the knowledge that they brought in . . . . The knowledge of how to listen to somebody, how to be humble, how to hear somebody else's words . . . . It gets overtaken by the agenda of medical interviewing. (Beagan, 2001, p. 280)

This is not, however, an open escape from the dilemma: ethics may be unteachable, but *phronesis,* by definition, is equally so, at least not in a classroom, with a lecture and ensuing test. Smith writes of its irreducibility to recipe, "the ethical potentials of *phronesis* cannot be instrumentalized or codified. *Phronesis* shows us that the vitality and integrity of a rhetorical culture cannot be reduced to or sustained by norms" (2003, p. 100). Thus, the turn to White Coat speakers, who help break the frame of defined, limited medical education with a start and a finish, by sharing with their audience the lessons they personally continued to learn even after they graduated. The indispensability of experience and immersion in particulars is given pride of place by being the kickoff message for the first year of medical school.

This perspective is not without its critics. Waring (2000) insists that medicine's infatuation with *phronesis* comes from a mistaken reading of Aristotle's repeated use of health as an *analogy* simply to *illustrate* the concept. He reminds his colleagues that the practice of medicine *produces goods,* which Aristotle claims *phronesis* does not, and that one can possess medical skill without applying it, whereas *phronesis* does not exist until *phronetic* acts are carried out. Hafferty and Franks warn that excess emphasis upon the doctor-patient relationship blinds physicians to the medical profession's impact *as a profession,* as a group of practitioners whose *aggregate* work changes surrounding conditions. But, as Toulmin reports, not only has the

idea taken hold in medicine, but medicine's appropriation of the concept has guided ethical deliberation in other fields as well:

> Professional obligations arise out of the enterprises of the professions in just the same kinds of way that other general moral obligations arise out of our shared forms of life; if we are at odds about the *theory* of ethics, that is because we have misunderstood the basis which ethics has in our actual *practice.* Once again, in other words, it was medicine -- as the first profession to which philosophers paid close attention during the new phase of "applied ethics" that opened during the 1960s -- that set the example which was required in order to revive some important, and neglected, lines of argument within moral philosophy itself. (1982, p. 746)

In the sections that follow, I will examine White Coat addresses and identify messages that inculcate medicine as *phronesis* in new medical students. The next section will identify commonplaces of which White Coat speakers have made widespread use. The section that follows will analyze four particular speeches. The final section will draw conclusions.

Conventions of the White Coat ceremony address

Medical schools are proud of their prestigious guests, and are quick to publish their words on their web pages, in their alumni newsletters, and, at times, in the pages of their medical journals. I obtained and examined thirty White Coat addresses, given between 1997 and August 2005. Seventeen of the speakers were faculty members, four were senior administrators (dean, vice president or president), one presided over the field's national organization, and one was the class president; another directed a county public health agency, and only one was listed as being in private practice. Most of the addresses took place at medical schools, but two occurred at pharmacy schools and one at a school of veterinary medicine.

All but two speakers told at least one story of their experiences with patients, with other doctors, or in medical school. Nine speakers quoted William Osler, one of the founding faculty members at Johns Hopkins Medical School and the doctor widely regarded as the architect of medical education in the United States. Only three attempted recognizable jokes; only one of the jokes was funny. One speaker noted that because he was extremely skinny, when he wore his white coat with a red tie, his classmates told him he looked like a thermometer (Cohen, 2002). Five major themes ran through most of the speakers' messages: the relationship between doctors from different eras, the importance of managing mistakes, the endless cycle of learning in a doctor's career, the fit between science and experience in medical practice, and the fundamental importance of the relationship between doctor and patient.

Intergenerational relations in the medical field

A common source of opening remarks was the breakneck pace at which scientific discoveries were remaking medical practice. Following the centuries-old technique of praising the field of medicine as a whole in order to welcome new medical students, (Siraisi, 2004) the speakers breathlessly announced that "The practice environment for the physician is changing

dramatically" (Sidel, 1998, p. 363), "Advances in science promise incredible excitement" (Groshong, 2001, ¶ 2), "This is an extraordinarily exciting time in medicine," (Rahn, 2002, ¶ 3), all seem to undercut the speaker's authority by introducing the possibility that the assembled students soon may have *more* current knowledge. One speaker even expressed envy of the students: "You are the most fortunate people on the face of the earth. You are going to be the physicians of the miraculous 21st century. Oh, how I wish I were starting all over again with you" (Abboud, 1999, p. 1). Some focused on new treatments and techniques, while others spoke of diseases that had become rare or even ceased to exist. But most used the remark as a springboard to direct attention to what they depicted as unchanging in medicine. In the most expansive phrasing of this claim, a speaker asserted that "…the core of the relationship between doctor and patient has remained surprisingly constant, from 5,000 years ago in ancient Egypt and Greece to our own time" (Siegler, 2005, ¶ 13).

One speaker spoke of new developments not as a sign that medicine had moved on, leaving tradition behind, but as raw material that would need to be processed into fully digested sustenance for continuing tradition: "Our challenge is to incorporate these advances into the care of individual human beings and not lose the tradition of caring and service that forms the foundation of the profession of medicine" (Rahn, 2002, ¶ 3). Another argued that the oceans of brand new knowledge placed a physician's emphasis *even more* squarely on the patient, not the array of available techniques:

> The current and anticipated explosion in medical knowledge should convince you that no one can learn all that is known - even all that is known about a specialized area of medicine. Thus it is important to realize that we must teach you how to evaluate your patients' problems and concerns, analyze data and findings, seek out new information, and apply what is known. (Kelch, 2003, ¶ 9)

One speaker noted that even before the rapid advance of medicine, even prior to its alliance with science, physicians were respected and honored by their peers (Siegler, 2005). Evidently, the prestige was rooted not in gadgets and elixirs, but in the doctors' practice of compassion.

Some speakers arranged the gleaming image of technological advancement into a more sinister vision. One argued that, despite all the new possibilities, "On the other hand, the problems facing the physician have become even more challenging. The increased ability to do good carries with it the increased ability to cause harm to the patient, the patient's family, and the community" (Sidel, 1998, p. 363). Another began his speech with a chilling recitation of statistics and study findings that tens of thousands of patients died each year because of physician error (Lillemoe, 2004), setting up for his audience the point that excellence was not an automatic by-product of medical practice, but could be forfeited with catastrophic consequences.

Others turned the unspoken charge of obsolescence on its head, claiming a greater understanding because of their long view. One speaker argued that her career gave her perspective on the impact of so many advancements: "With decades of clinical experience, we older physicians can truly appreciate new developments for treatment or diagnosis because they avoid some of the patient suffering we witnessed in the past" (Ephgrave, 2000, pp. 1-2). And one laid claim both to expertise and to affiliation with the audience, promising to speak "not as your dean, but rather as a physician who sat in those seats exactly 30 years ago, and has spent his career educating young physicians, and caring for patients" (Nasca, 2001, p. 4). And several speakers made the case that doctors ought to learn from other doctors, that "a real key to success is role models" (Lillemoe, 2004, ¶ 13), that "a dose of advice or wisdom from their experience, … can be invaluable in guiding you" (Lawrence, 2004, ¶ 28). If *phronesis* is developed through practice, then those who have accumulated experience are highly desirable deliberative partners, although second to the patient. White Coat speakers were quick to put rapid change in medicine

into perspective, drawing together ties between generations of doctors and lowering the importance of current data and cutting-edge technique compared to good sense.

Mistakes

White Coat speakers made several common points regarding mistakes that injure a patient. First, they gloomily assured students that mistakes were inevitable, that "you will. You will make them. Everyone makes mistakes, even doctors" (Groshong, 2001, ¶ 13), that "Mistakes are inevitable, not discussed during training or in practice often enough, and sometimes they do have long-term consequences for the patient," (Johnson, 2003, ¶ 47). Their advice for handling such mistakes scattered a bit, ranging from humor (Cohen, 2002) to naked honesty (Ephgrave, 2000), but the recurring suggestion was to *learn* from the mistake, consider it a blessing: "mistakes learned from ultimately make you better, in fact, as much as you should try to prevent them, in some sense, you must also welcome them" (Johnson, 2003), and use it as an opportunity to improve:

> Ask how you might have handled a challenging situation differently; how you might have asked a more open-ended and less judgmental question; how you might have paid attention to what was not said as well as what was spoken; and how you could have known that the patient's body language was telling you something entirely different from what he was saying. (Kelch, 2003, ¶ 15)

Again, the speakers' focus was not on rules or formulas to follow, but on the necessity of experience and the impossibility of scripting one's engagement with medicine and with patients.

Nonstop learning

A very popular theme among White Coat speakers was the extension of learning beyond the end of formal medical education. "Even though you might not be a medical student, you will be a student of medicine for the rest of your life," (Adams, 2001, ¶ 12). One speaker, a

pediatrician, titled his speech "Growth and Development of a Physician" in order to focus on the point that "personal growth and professional development is or should be a lifelong, continuous process for physicians" (Kelch, 2003, ¶ 2). In developing the point, he captured a striking confluence of phronesis and the White Coat ceremony by delivering directly to his audience the message that they were ignorant of his point even as they listened to it:

> … the attainment of wisdom requires considerable personal growth - growth in self-awareness and growth in your ability to manage your feelings, attitudes, beliefs, and life experiences. I did not fully understand these requirements when I began medical school and I suspect that most of you as students do not have a complete understanding either. (Kelch, 2003, ¶ 12)

Another speaker promised as yet unforeseen lessons, drawing on her own experience as proof: "Yet--- I will guarantee you that 7 years after you graduate, most of you will be practicing your profession in a way that you have not even considered today. How do I know that is true? – because that is exactly what happened to me" (Walther, 2003, ¶¶ 4-5)

One speaker described lifelong learning as not just a reality, but an obligation taken on for the patients' benefit: "Every day, your patients will count on you to know more than you did yesterday. To do less would be to disappoint yourself and to admit failure to yourself and your patients" (Raimer, 2004, p. 2). Similarly, another described it as a renewal of the bond with patients: "You are embarking on a lifelong commitment to earn that trust every day of your professional life. The real import of today's ceremony is the symbolic demonstration of your acceptance of this challenge" (Rahn, 2002, ¶ 4). Another characterized it as one of the intangible rewards of practicing medicine: "You will be acquiring new information about a dramatically changing profession on a continuous basis. You will learn something new every day. This is one of the aspects of medicine that I hope you will cherish" (Adams, 2001, ¶ 12). Finally, one speaker

urged the audience to continue expanding their knowledge not only in *depth,* not only *within* the field of medicine, but in *breadth,* in matters *beyond* its purview: "I challenge you to be lifelong learners not only of medical facts and figures, but also of all sources of wisdom, including the social sciences, the arts and the humanities. The more well-rounded you become, the better doctor you will be" (Rothstein, 2001, p. 225). Learning, then, instead of being a phase *preparatory* to the practice of medicine, instead of being what comes before one begins practicing, was for these speakers an inseparable *element* of practice; as they practiced, they learned, and any moment spent learning was a moment spent practicing. The lessons learned and taught through that process are the substance of *phronesis*.

Blending science and experience

If a chief task of the White Coat speaker was to help the students put knowledge in perspective and harness that knowledge to service, then the speakers met that challenge with zeal. The interface between medical science and medical practice was a dominant and recurring theme in the speeches. One speaker pointed out that the knowledge of medicine is most conspicuous when its shortcomings become apparent: "… every practicing physician knows that 'just the facts' is not enough. It is rather the ability to integrate all these facts, and, equally as important, to understand what you do NOT know, and to be able to apply all this to the particular circumstances of the individual patient sitting in front of you" (Johnson, 2003, ¶ 21). Another emphasized that the knowledge was an *instrumental* good, valuable only because it enabled serving the patient, which was a *terminal* good: "You will acquire that knowledge at the price of hard work. In return, that knowledge will confer to you the privilege and the power to heal and comfort the sick, to alleviate their agony and pain, to a degree that was unbelievable just a decade or so ago" (Abboud, 1999, p. 1), reiterating Aristotle's point that a *phronimos* acts in ways that are themselves good, not producers of other goods. Studying was simply preparation; the practice

of medicine was the *per se* good. Still another speaker located the concept within his definition of *professionalism:* "To me, professionalism is an attitude. It is a part of your existence. It's about using your knowledge, to innovate, to create an easier way, a better way to practice. It's about keeping up with your knowledge, reading journals in your field and in other fields that may improve your ability to practice" (Tertes, 2004, p. 5). But most focused on this theme was a speaker who contrasted cutting-edge surgery to community clinics in order to make the tension between the two vivid in his audience's minds:

> Most of you will also become specialists of one form or another. You will define yourself by an organ or a disease, or even a protein or a gene, but you must never forget that it is much more difficult to be that general doctor who lives by Dr. Edward Trudeau's maxim, "to sometimes cure, often help, always console." If you want to burn this into your brain early in medical school, please join me, two or three at a time to witness this tension between the art and the science of medicine by spending some time in a very high-tech, computerized operating room and a very low-tech, hands-on outpatient clinic. (Spencer, 2003, ¶ 10)

He concluded, "The white coat for me symbolizes that you are that link from the laboratory to the bedside and back again. You must wear the white coat comfortably in both places, speak both the language of science the language of caring" (Spencer, 2003, ¶ 23).

Medicine as a relationship

As intently as many speakers addressed the interface between science and experience, that theme, and all others, were dwarfed by the relentless return to the centrality of the doctor-patient relationship. Speakers compared patients' trust to "the trust we place in our religious leaders. It is instantaneous (not individually earned based on years of personal contact), and it is all encompassing" (Nasca, 2001, p. 5), emphasizing that "…they believe in us, many with the faith

of children…" (Fisher, 2004, p. 1167). They warned the students that "You, the highly intelligent, goal oriented individuals we accept into medical school, often initially find this level of personal insight, vulnerability, and receptivity threatening or uncomfortable" (Nasca, 2001, p. 6), but sternly instructed them to take on the trust, even to the point of subordinating their own wishes and interests to those of their patients:

> You need to recognize that the patient, not you, is the most important person in the patient-doctor relationship. You will need to be as aware of your patients' needs and well being as you are knowledgeable about their illness. You must recognize that the desires and emotions of the patient in the patient-doctor relationship differ from yours. (Adams, 2001, ¶ 14)

They spoke at length about *why* the doctor-patient relationship was so special, arguing that it was the foundation of medicine's enduring prestige: "In my view, it is the sanctity of the doctor/ patient relationship that has sustained our profession through the ages, enabled the word 'doctor'—more importantly, 'my doctor'—to command instant respect and admiration" (Falk, 2003, p. 153), pointing out that in their lifetimes they would find themselves on *both* sides of the stethoscope: "…not only am **I** a patient … but the ward clerk may show up in my clinic with ulcers next week, and the occasionally distracted nurse working beside me in the OR may have both health and social problems that I would find insurmountable. In other words, we are **all** patients" (Ephgrave, 2000, pp. 3-4), and promising that the relationship itself was one of the greatest sources of joy in the profession:

> I was forced to recognize, acknowledge, and then shed my personal biases in order to become receptive to the thoughts, feelings, and needs of my patients. I was challenged to provide the same level of empathy and compassion to each patient, regardless of his or her social status, economic means, and level of reciprocation of trust and kindness. I was

> invited to be open to the gifts each person brought to the relationship. These gifts include the opportunity to serve, to share in the pain as well as joy of the patient, and to rejoice in the triumph of the human spirit over the physical limitations that we all possess. Perhaps the greatest gift I have received has been the touching of my soul by my patients. (Nasca, 2001, p. 6)

They gave advice, some drawn from their own family members: "Over the years, members of my family, especially my mother, have taught me much about the characteristics of excellent physicians. My mother would say, 'He or she must know what they're doing, but I want them to listen to me and I want to feel that they care about me' (Kelch, 2003, ¶ 3), some involving *thinking* of the patients as interchangeable with family members:

> Almost daily in my practice, an adult child of an elderly patient, or a wife or a husband, will ask me, when faced with difficult medical choices, "Doctor, what would you do if it was your mother, or your wife, or your child?" And that is what it really is all about: the doctor/patient relationship and doing our best to treat each member in the family of man as if they were a member of our immediate family—because they are. (Falk, 2003, p. 155)

And some of the advice was as simple as using an honorific to maintain a patient's dignity in a difficult and stressful situation:

> An immediate way to gain trust and confidence from your patients is to demonstrate respect for them, and in so doing, abate the inherent superior position you possess in the doctor-patient relationship. Don't be afraid to call someone "Sir" or Ma'm", very few people object to these terms if you are sincere. Far more will appreciate the understated respect they imply. (Lawrence, 2004, ¶ 14)

Finally, with this theme more than any other, speakers were quick to ground their observations in the tangible, touchable reality of the white coat. They spoke of it as a token of

trust: “The white coat, like the robes of the judge or the cloth of the clergy, has meaning not only to the wearer, but to those who observe it being worn. There is an inherent expectation, an unwritten word, a bond. The fiber of the garment is made of trust” (Cohen, 2002, p. 220), of compassion: “However, most of all, I hope this coat will become a symbol of compassion for you. It is my hope that you will not remain at a distance or be separated from your patients, but rather that you will be drawn even closer to them” (Raimer, 2004, p. 1), and of returning respect for respect given: “Remember that dignity is easily lost with ill health; later today you will be donning white coats, an act which has many symbolic elements. Among them is an implicit respect from patients; do what you can to reciprocate that respect, and in the process maintain their dignity” (Lawrence, 2004, ¶ 16). As the patient is the reality, the material grounding of all the rules, descriptions, models and methods of medical school, the patient is the site of *phronesis,* the recipient of medical treatment, the *entire point.* And because the patient is not a tool or an ingredient, but another person, proceeding to enact medical science with the patient must involve exchange and negotiation of perceptions, ideas, messages, in a deliberative process that, properly guided by feedback and by more experienced physicians, holds out the hope of transforming a medical student into a *phronimos.*

In this section, I have focused on elements of the *message* that correspond to the medical field’s appropriation of *phronesis* to explain the experiential nature of medical ethics and best medical practice. In the next section, I will examine entire speeches, foregrounding individual *speakers’* apparent designs in addressing their audiences.

Four addresses

Stephen J. McPhee, a professor, addressed the University of California San Francisco incoming class of first-year medical students in 2000. His speech stayed focused on the white coat more than most; he developed the speech as a catalogue of the things he ordinarily kept in

the pockets of his white coat. He set up the device at the beginning of his speech, admitting to a fairly traditional orientation to workplace dress:

> I must admit that I was surprised to be asked to speak to you about the meaning of the white coat. This was partly because I didn't know a great deal about the origin or history of the white coat. On further reflection, I decided I must have been asked simply because, in the somewhat informal culture and dress code at UCSF, I was one of only a few faculty who *always* wore a white coat! (McPhee, 2000, p. 677)

Fulfilling Freidson's profile of a physician, McPhee arrived at the theme of his speech by constructing it on top of a very practical, solution-oriented habit of thinking: "I wear my white coat simply because it is useful to me, because of its many pockets. My white coat lets me carry things with me, on my person. Each of these things has practical importance. But in thinking about them, I realized that each of them also has metaphoric significance for my work as a physician" (p. 677).

Of the fifteen items Dr. McPhee keeps in his pocket, four are described as clearly symbolic of the patient's immediate needs: the ID badge, which opens a conversation; the stethoscope, which signals listening and makes a physical connection; the tongue blade, which reminds him of a patient's discomfort; and a card with Psalm 91 and a poem on it, which he uses to console those in grief. Three objects remind him of the specialized knowledge he brings to medicine: the ruler, which symbolizes measurement; the calipers, which symbolize interpreting diagnostic tests; and the laser pointer, a gift from a former student, which reminds him of his obligation to teach others. Six other objects fall into *both* categories: the prescription pad symbolizes the role of medication in therapy, but the triplicate pad for prescribing pain killers also reminds him of patients' suffering; the three pocket reference books contain accumulated and indexed knowledge about technique, but they *also* communicate to patients that he does not

consider himself infallible; and the penlight reminds him that his diagnosis casts light, but that the light it casts illuminates a patient's situation.

McPhee teaches his audience that each time they apply themselves to a medical task, they both carry out instructions and put themselves at risk; they work with both hands and heart. His connection of the coat to tools expresses the needs of patients and young doctors not in lofty principle, but in very practical, tactile terms oriented to busy-ness. He concludes,

> In a moment, we your faculty will help you put on your white coats for the first time as physicians in training. Today, the pockets of your coat will be empty, but soon you will begin to fill them with your own tools, your own experiences. I hope that when your pockets are full of a number of things, they will serve you as well as they have served me. I hope that your patient encounters will prove to be as much a source of strength for you as they have for me. (p. 679)

Benjamin L. Cohen, provost of the University of North Texas Health Science Center, had less opportunity to pursue a lighthearted conceit in his White Coat Ceremony address, given on September 14, 2001. He began his unenviable task of heartening and motivating a group of students struck by shock and grief from the events of just three days before with words appropriate to the recent events, if not the occasion, promising that a respite from grief was on its way:

> There are no words that can remove the grief, the horror, and the magnitude of this past Tuesday's events. We are all relatives of the victims. The cloud of smoke and debris from New York and Washington has covered our country and undoubtedly will linger. However, soon there will be rays of sunlight piercing through the clouds. These rays will be that of the perpetual spirit of the police and firemen [sic] who gave their all in attempting to preserve the sanctity and dignity of human life. This enduring commitment

> to the highest values of the civilized world makes these heroes kindred spirits to the professions of this institution dedicated to the health of the nation. It is the continuum of life. It is in the spirit of hope that we open our doors to new students, and it is in that humble way we celebrate their arrival today. (Cohen, 2002, p. 219)

Cohen employed a striking rhetorical device, almost redolent of a young Martin Luther King, peppering his audience with rhythmic barrages of questions, each beginning with "Will you?" The first bundle of questions dealt with the awe students may feel while reflecting on the sweep and scope of scientific knowledge: "Will you be astonished with the genius of nature's law, the profundity of the DNA structure and its function, the enigma of life's continuum? Will you be astonished at the efficiency of the cell and the eloquence of the cellular wall?" (p. 221). The second bundle dealt with wonders closer to home: "Will you marvel at the crowning of the first delivery? Will the baby's first cry send a tingle down your spine and a smile to your face?" (p. 221). Each sequence has the cadence of poetry, but each also has the structure, order and regularity of a recitation. One speaks of science and ordered knowledge, the other of raw experience, and each partakes of the other's mode of expression.

Cohen told the story of treating a woman whose son was dying of leukemia, and had gone into seizures. The mother was convinced that the seizures were answers to her prayers, that they were God's way of purging the leukemia from her son's body. Cohen medicated the boy to stop the seizures and explained to the mother what he had done. At the mother's insistence, he was removed from the boy's case, and the boy died soon after. Cohen explained to the audience that while he may have acted as medical propriety indicated, he had mis-stepped badly by ignoring the mother's need for hope. He transitioned from that story into a third bundle of "Will you" questions, this time about death: "Will you be at the bedside when the transition from life occurs? Will it send you home thinking, questioning, prioritizing?" With that sentence, Cohen

changed from wondering aloud to confronting his audience: “Do you know that it is a sacred privilege to be present even at times of futility? Do you know it is an honor to care for patients, an exalted duty to care for the poor and less fortunate?” (p. 221). Having talked about a number of life-changing experiences, Cohen consolidated his point into something between a prediction and a promise:

> If in your reflections you can be moved by these phenomena and challenges, then there will be a magic moment in time. There will be a coalescence of experience and awareness that you will feel, “I am a doctor. I am a scientist. I am a public health specialist. I am a physician assistant.” And for the rest of your life, you will be inexorably drawn into that feeling and each of you will have an opportunity to be what thou art. (p. 222)

And finally, Cohen employed the commonplace of talking about recent rapid advances in medical knowledge, but gave it an unorthodox spin by taunting his audience to match the accomplishments of his generation of physicians:

> When I graduated, we did not have Medicare or Medicaid, managed care or HMO’S, kidney, heart, or lung transplants, CT scanners or MRI’S, AIDs or Ebolas, faxes or computers. But we challenged every day, we invented, we changed, we accommodated, we increased the lifespan, and in some areas even decreased suffering. We have met many challenges but certainly not all, and we have learned that the vehicle for wisdom is experience. What will your world look like when you attend your child’s white coat ceremony? Can we do better? Can you do better? (p. 222)

Dr. Susan R. Johnson, Professor of Obstetrics, Gynecology and Epidemiology at the University of Iowa Medical School, as well as being Associate Dean for Faculty Affairs, addressed the incoming class of medical students on August 22, 2003. She divided her address into three parts. The first was an extremely precise and academic lecture on the nature of

authority; she explained T. T. Patterson's theory that doctors exercised a combination of "sapiential," "moral" and "charismatic" authorities, or, as Aristotle might respectively label them, logos, ethos and pathos. She interrupted it briefly to explain to her audience that she became interested in medicine when she was a child after she read a picture book about tuberculosis germs dressed up in Nazi uniforms, attempting to blitzkrieg a human lung.

The second section of Johnson's address was a poem, apparently composed by her, entitled "24/7." The poem described the unending, unbroken responsibility of a physician, including middle of the night emergencies and interrupted weekends. It concluded, "24/7: cures, needs, adrenaline, fatigue, 'saves,' uncertainty, exhilaration, trouble, ... the truth" (Johnson, 2003, ¶ 35)

The third and final section was about connection with others. Dr. Johnson called several students by name from the podium and challenged them not to fall prey to mistakes of ego: "At first glance it seems that it must require superhuman effort to be a physician. But it does not -- it only requires your best human effort. In fact, it is those physicians who attempt to be superhuman who often fail -- themselves, their families, and ultimately their patients" (¶¶ 38-39). And in her third and last bit of advice, Dr. Johnson captured the concept of *phronesis* by fusing accomplishment, joy in work, and the doctor-patient relationship:

> The number one factor enhancing satisfaction in most surveys, which will come as no surprise, is having developed "A personal sense of competence." In a recent study by Horowitz, the other factors identified had to do not with the achievement of spectacular cures, or technological wizardry, but rather, with the development of relationship to patients (¶¶ 54-55)

She ended her speech by "assigning" the audience to go to public places, look at strangers, and make a conscious choice to think of them as patients *and* people with separate identities, to

practice the moment of connection with an unfamiliar person until it was no longer strange or awkward.

Finally, Ken Davenport, class president of the University of South Alabama medical students, spoke at the 2004 White Coat Ceremony. In very traditionally epideictic, almost florid, language, Mr. Davenport dug straight in to the problem of reconciling medical science to human interaction and relationships:

> At once a soldier of science with its fastidious demand for reason, logic, and empiricism there is, however, that character of medicine that transcends the concrete and unyielding realm of science. It is this very character that separates the clinician from the scientist and ultimately medicine itself from the other pool of noble professions. This elusive attribute finds no solace in the comforts of science. It instead embraces the mercurial, the amorphous, the intangible. (Davenport, 2004, ¶ 1)

Freidson's sore spot for medical professionals does not appear in Davenport's hands to be a sore spot, but rather a mark of distinction and identification. He captures the bridging concept between knowledge and practice after a few false attempts, reviving yet another classical Greek concept to explain his perspective:

> While medicine must be rooted soundly in science, it must also bow the knee to the other great pillar of its majestic edifice. This pillar has been called many things - Art, Empathy, Feeling. Even the early physician-scientists grasped this duality as they realized that there was something beyond the mechanical systems of the body that, once removed, irreversibly separated the body from its life. The Greeks termed this essence the pneumos which we translate "breath" and from which we get our field of pneumatology but to the ancient Greeks far more meaning was signified by this term. Pneumos represented much more than the mere air that was exhaled and inhaled. It instead represented the soul of

> that person – that essence that somehow embodied their very existence and identity. So it is with medicine for without this pneumos medicine, like the human machine it serves, would be a lifeless corpse – incapable of activity and devoid of life. (¶ 1)

Finally, in a breathtakingly evocative device, Davenport pins down and identifies the nature of *phronesis* in medicine:

> Our class also owes an equally unpayable debt to the teachers, faculty and dean of our basic science years for their untiring commitment to our education and their demand for excellence. It is their early grooming that prepares us for our clinical experience and most of what we will draw from in our practices will be from lessons taught by our professors these past two years. From the intricate vocabulary of these basic science years will come the poetry of our clinical practice. (¶ 4)

All four speakers departed from convention, made unique choices corresponding to their own style, and crafted a message to the incoming class of students that drew from the moment, not from the rulebook. All adopted some predictable elements, but made other choices that individualized their messages and allowed the students to *experience,* not just *hear,* the impact of responding practically, with theory a distant and fading consideration.

Conclusion

Ellen Rothman found the White Coat Ceremony unsatisfying, and the symbolism of wearing the coat unsettling and unclear. Despite these growing pains, she looked forward to growing into her white coat. Suchman et al. acknowledged such shortcomings in their mission statement, determining to "make ripples in a pond" instead of trying to frog-march students through choreographed, catechistic discussions of ethical rules from the medical rulebook.

The White Coat ceremony is not magic, any more than a mayor saying a few words at the ribbon-cutting for a new building can manage to miraculously assemble the entire building in the

blink of an eye with a hearty *allakazaam!* It is, however, a challenge for students to think about their thinking, to recognize that the learning they do within the four walls of the school is a subset, and not a completion; a starter kit, and not a complete set of working tools. If centering the patient's needs in the decisionmaking realm holds any promise, if teaching doctors to watch for lessons and balance science with experience exerts any corrective effect on the depressing toll of medical mistakes, then the White Coat ceremony is a worthwhile supplement to students' education. The elements of *phronesis* are everywhere, illustrated and performed in unpredictable, provocative, and even occasionally entertaining ways. We are not present at the birth of the White Coat ceremony, but we have arrived in time for its teenage years. They promise to be neither pretty nor reassuring, but something better and more complete is on its way.

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